CLARITY COUNSELING, INC.

ADULT INTAKE FORM

Please complete this form in order to expedite the counseling process.

Date: _____ Name: _____

SSN: _____ DOB: _____

Religious Background: _____ Gender: _____

Family of origin information (include name, age, and type of relationship with each family member):

Father: _____

Mother: _____

Sibling(s): _____

Others: _____

Currently living with (include name, age, and type of relationship):

_____

_____

_____

_____

Educational Background (include areas of interest and dates of graduation, if applicable):

_____

_____

Legal History:

Ever been arrested? _____ If yes, indicate arrested for what and when: _____

_____

Developmental History: Any significant developmental issues? _____ If yes, describe _____

_____

Trauma History: Experienced past trauma? _____ If yes, describe _____

_____

Medical History: Any medical issues? _____ If yes, describe _____

_____

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5907 Alice NE Suite A, Albuquerque, NM 87110
Phone: (505) 294-2722 Fax: (505) 294-2922

Date of last medical exam: _____ Medical Doctor & Phone #: _____

Psychiatric History: Attended counseling previously? _____ If yes, describe _____

_____

Psychotropic Medications: History of taking psychotropic medications? _____ If yes, describe _____

_____

_____

Alcohol/Drug Usage: Currently use alcohol or drugs? _____ If yes, describe (e.g., types, frequency, past history): _____

_____

_____

Suicide Risk: Ideation or attempts (past and/or present)? _____

If yes, when? _____ How many times? _____

What were the circumstances at the time? _____

Abuse History: History of being physically, emotionally, or sexually abused? _____ If yes, describe _____

_____

_____

Circle the following symptoms/behaviors experienced in the last thirty days:

Sleep Disturbance	Weight Change	Lack of Motivation	Unemployment
Change in Eating Behavior	Restlessness	Physical Complaints	Easily Annoyed or Irritated
Bedwetting	Uncontrolled Outbursts	Guilt/Remorse/Shame	Strained Relationships
Nightmares	Uncontrolled/Unprovoked Crying	Lack of Concentration	Feelings of Depression
Anxiety	Difficulty with Decisions	Loss of loved one	Panic Attacks
Aggression	Nervousness	Fear	Self-Harming Behavior
Tension	Negativistic		

Others: _____

Support Systems: Do you have supportive people in your life? _____ If yes, include contact information (in the event of an emergency)

_____

Strengths: Personal strengths? _____

_____

Presenting Issues: Briefly explain reason for seeking counseling at this time: _____

_____

Goals for counseling: _____

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